PRINTED: 10/16/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
		B. WING				09/25/2024		
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP COD 7365 E 16TH ST INDIANAPOLIS, IN 46219					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE	
R 0000								
Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00436183, IN00442123, and IN00442126. Complaint IN00442123 - No deficiencies related to the allegations are cited. Complaint IN00442126 - No deficiencies related to		R 00	000				
	the allegations are complaint IN00436 the allegations are	6183 - No deficiencies related to						
	-	ember 24 and 25, 2024						
	Facility number: 00	05729						
	Residential Census	: 31						
	These State Reside accordance with 41	ntial Findings are cited in 10 IAC 16.2-5.						
	Quality review con	npleted on September 26, 2024.						
R 0273 Bldg. 00	410 IAC 16.2-5-5 Food and Nutritio	.1(f) nal Services - Deficiency						
	review, the facility stored in the refrige floor in the freezer, free of ice build-up machine had adequ	on, interview, and record failed to label and date items erator, store items off of the censure items in the freezer were of and to ensure the dish thate amounts of sanitizer during in the potential to affect 31 of 31	R 02	273	Submission of this plan of correction does not constitute an admission of guilt. All residents were found to have been at risk for potential hard of said issue, however no residents were harmed were found to have been harmed.)	10/17/2024	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE	

LORI WEAVER EXECUTIVE DIRECTOR 10/09/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/25/2024			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7365 E 16TH ST					
CROWN	POINTE OF INDIA	NAPOLIS		INDIAN	NAPOLIS, IN 46219			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	residents residing at the facility.							
	+				In Re R273 Dietary In an effort to identify why the food was placed in storage without the proper labeling, why there was expired food the refrigerator, why the box of food were placed on the floor of the freezer and why there were ice crystals were forming on the items in the freezer, and why wasn't the sanitizer reading at an appropriate level As a means to ensure compliance: Interviews were conducted wi dietary staff. It was determine that the sanitizer line was accidentally placed into the detergent bottle, simply huma error. It was reported that box of freezer goods were placed the bottle (aka floor) of the free due to lack of freezer space. The lines on the dish machine run to the sanitizer and detergon have now been color coded. The Director of Dietary has repackaged and labeled some	th the ed nesson ezer e that gent		
	storage containers should be labeled with what was in the container and the date it was placed in				the freezer food and re organi			
	the refrigerator. The expired milk should have				the freezer to get all of the box			
	been thrown away. She was unsure why there				of food off the floor. Corporat			
	was ice crystals on the pork loin. The boxes were				ordering an additional freezer			
	on the floor of the freezer because of lack of				storage space as well.			
	storage space in the freezer.				As a means of quality assure	ance		
	- *				All dietary staff will be re-educ			
	The low temperature	re dish machine was observed			and in-serviced on proper foo			
	_	24/24 at 10:15 a.m. During the			storage and shelf life, dating a			
	rinse cycle, the sanitizer was measured at 10 parts				labeling of all food stock in the			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPL	LETED
			B. WING			09/25/2024	
		l	1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			16TH ST		
CROWNPOINTE OF INDIANAPOLIS					APOLIS, IN 46219		
CINOVIN	CINTL OF INDIAL	•/··· OLIO		וואטואוו			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		The DM indicated it should be			dietary department, whether it		
	100 ppm during the	e rinse cycle.			dry stock, cooler or freezer, or		
					even in the little reach in coole	er.	
	_	v on 9/25/24 at 9:50 a.m., the			All dietary staff will be		
		indicated the supply line for		re-introduced and in-serviced on a			
		en placed in the detergent			new check sheet called a		
		The sanitizer line should have			5-minute check, where they sp		
	been placed in the s	sanıtızıng solution.			the first 5 minutes and the last	t 5	
	<u></u>	0/05/04 / 10.00			minutes of each day double		
	_	v on 9/25/24 at 10:00 a.m., the			checking on important tasks, i		
	Interim Director of Health Services indicated the				checking the storage areas fo		
	facility used the Indiana Retail Food Manual as				unmarked or unwrapped, expi		
	their dietary policy for food storage and sanitation			or open foods, checking the log			
	of dishes.			sheets for proper documentation of completed tasks. See attachment			
	The Detail Food Establishment Societion					nent	
	The Retail Food Establishment Sanitation				#1		
	Requirements, dated November 13, 2004, indicated				All dietary staff will be in-servi		
	the following, "Sec. 294. (a) A chemical sanitizer				on the proper identification of		
	used in a sanitizing solution for a manual or machine warewashing operation at exposure times				sanitizer bottle and line, the line are now color coded to ensure		
		tion 303(b)(3) of this rule shall			the bottles and lines coordinate		
	_	. 178.1010, used in accordance			All dietary staff will be re-educ		
		rer's label use instructions as			and in-serviced on proper food		
		441 of this rule, and used as			storage and shelf life, dating a		
		(a) Except as specified in			labeling of all food stock in the		
		(c), food shall be protected			dietary department, whether it		
	from contamination by storing the food as				dry stock, cooler or freezer, or		
	follows (3) At least six (6) inches above the				even in the little reach in coole		
	floor. (4) In a manner to prevent overcrowding. (5)				All dietary staff will be		
	In packages, covered containers, or				re-introduced and in-serviced	on a	
	wrappingsSec. 191. (a) Except as specified in				new check sheet called a		
	subsection (d), refrigerated, ready-to-eat,				5-minute check, where they spend		
	potentially hazardous food prepared and held in a				the first 5 minutes and the last	• •	
	retail food establishment for more than			minutes of each day double			
	twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall				checking on important tasks, i	е	
					checking the storage areas fo		
		e premises, sold, or discarded,			unmarked or unwrapped, expi		
		the temperature and time			or open foods, checking the lo		
	` ′	fied as follows and the day of			sheets for proper documentati	•	
preparation shall be counted as day one(1)					completed tasks. See attachr		

State Form Event ID: LN8P11 Facility ID: 005729 If continuation sheet Page 3 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	e survey pleted 5/2024
	PROVIDER OR SUPPLIE		7365 E	ADDRESS, CITY, STATE, ZIP 6 16TH ST NAPOLIS, IN 46219	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	PRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Forty-one (41) deg maximum of seven	rees Fahrenheit or less for a (7) days"		#1 Per our service rep from the line for sanitizer work inadvertently placed in bottle of detergent. Santachment #2 All diet be in-serviced on the identification of the sand line, the lines are coded to ensure that and lines coordinate R273 Corrective Active How will the facility in other residents having potential to be affect same deficient proactive active acti	n to the See tary staff will proper anitizer bottle now color the bottles fidentify ing the ted by the ctive and on will be a potential to be put into inic will make efficient be not dietary team 10/16/24 with ertified by Topics od storage proper ind cookware achine. Tryiced by the the temp ish machine checking	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTEROTOR	THE TOTAL CONTESTS	THE SERVICES				•	21.0.0,00	
STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED		
			B. WING			09/25/2024		
				_		33,20	·	
NAME OF E	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
TVIIVIL OF I	RO VIDER OR SOLTEIER			7365 E	16TH ST			
CROWN	POINTE OF INDIAN	NAPOLIS	INDIANAPOLIS, IN 46219					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
					A 5-minute check list will be			
					introduced to dietary staff and	all		
					will be expected to complete t			
					list at the beginning of his/her			
					shift. See attachment #1.			
				How will the corrective ac		ns		
					be monitored to ensure the			
					deficient proactive will not			
			reoccur, ie. What quality					
			assurance program will be pu					
				into place.				
					The Director of Dietary or des	ignee		
					will monitor the refrigerator, fro	•		
					and dry stock food storage are			
					as well as the chemical testing			
				for the dish machine. This wil				
				conducted randomly at least 3				
			times a week for 3 months at					
				which time it will be determine	ed if			
		this monitoring and documentation						
		is still needed or will continue for						
		an indefinite period of time.						
				The Administrator or designed	with			
					monitor the documentation log			
					weekly as a second check to	,		
					ensure compliance and this w	ill		
					continue for at least a 3-montl			
					period and at which time it wil			
			determined as to whether or not to					
					continue for an indefinite perior			
				time	JU 01			

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